Lancaster County
Enrollment/Change Request

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Aetna Life Insurance Company
Visit us at www.aetna.com

Employer Group Information:

Employer Name	Employer Address (City, State, ZIP Code) - Primary Location	Control	Suffix	Account	Plan Option
Lancaster County	555 S. 10th Street, Lincoln, Nebraska 68508	285745			Aetna Choice® POS II

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. Please print clearly.

☐ New Application (Complete all sections except Section C) ☐ Change (Complete all sections except Section B, if applicable)

A. Employee Information - Employee Completes Sections A - E.

Social Security Number	Last Name	First Name	M.I.	Title

Address (Street, P.O. Box)	City, State	Zip Code

Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	Telephone Number	Date of Hire (mm/dd/yyyy)	Marital Status
				☐ Single ☐ Married ☐ Divorced

B. Health Election(s) for Newly Eligible Employees:

I herby elect coverage for: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family ☐ Waive

C. Type of Activity:

Change *Check all that apply.* ☐ Add Spouse ☐ Add Dependent Child ☐ Name Change ☐ Other

Reason: | **Date of Event**

Remove or Terminate *Check all that apply.* ☐ Remove Spouse ☐ Remove Dependent Child ☐ Employee Withdrawal/Termination ☐ Cancel Coverage

Reason: | **Date of Event**

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals covered - List individuals for whom you are adding/changing/removing coverage

List below spouse and other dependent(s) to be covered including eligible children under age 26. List in order of age - oldest first.

A(dd) C(hange) R(emove)	Name (First, Middle Initial, Last)	Social Security Number	Date of Birth (mm/dd/yyy)	Sex M or F	Relation to Employee

E. Employee Signature

☐ *By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit Aetna Navigator®.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.

Employee Signature - *Required*	Date	E-Mail Address	Primary Spoken Language

Lancaster County Official Use Only:
Effective Date:
Department:

Please make a copy for your records.